SENATE BILL No. 503

DIGEST OF INTRODUCED BILL

Citations Affected: IC 4-22-2-37.1; IC 12-7-2; IC 12-15; IC 12-16; IC 27-8-10.1; IC 34-30-2-45.2.

Synopsis: Healthier Indiana insurance program. Establishes the healthier Indiana insurance program and the healthier Indiana insurance program fund. Makes funding changes to the hospital care for the indigent program, the municipal disproportionate share program, and the Medicaid indigent care trust fund. Requires the Indiana comprehensive health insurance association to establish the health for high risk Hoosiers program to provide coverage to certain individuals referred to the program by the office of the secretary of family and social services. Requires the office of Medicaid policy and planning to apply to the United States Department of Health and Human Services for: (1) a demonstration waiver to develop and implement the healthier Indiana insurance program to cover certain individuals; and (2) an amendment to the state Medicaid plan to cover pregnancy related services for pregnant women whose annual household income does not exceed 200% of the federal income poverty level. Repeals certain provisions concerning payments to hospitals and the hospital care for the indigent program.

Effective: Upon passage; July 1, 2007.

Miller

January 23, 2007, read first time and referred to Committee on Health and Provider Services.



First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in this style type. Also, the word NEW will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in this style type or this style type reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

SENATE BILL No. 503

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1	SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.47-2006
2	SECTION 2, AS AMENDED BY P.L.91-2006, SECTION 2, AND AS
3	AMENDED BY P.L.123-2006, SECTION 12, IS CORRECTED AND
4	AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]
5	Sec. 37.1. (a) This section applies to a rulemaking action resulting in
6	any of the following rules:
7	(1) An order adopted by the commissioner of the Indiana

- (1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.
- (2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.
- (3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.
- (4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.



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1	(5) A rule, other than a rule described in subdivision (6), adopted
2	by the department of financial institutions under IC 24-4.5-6-107
3	and declared necessary to meet an emergency.
4	(6) A rule required under IC 24-4.5-1-106 that is adopted by the
5	department of financial institutions and declared necessary to
6	meet an emergency under IC 24-4.5-6-107.
7	(7) A rule adopted by the Indiana utility regulatory commission to
8	address an emergency under IC 8-1-2-113.
9	(8) An emergency rule adopted by the state lottery commission
.0	under IC 4-30-3-9.
.1	(9) A rule adopted under IC 16-19-3-5 that the executive board of
.2	the state department of health declares is necessary to meet an
.3	emergency.
.5	(10) An emergency rule adopted by the Indiana finance authority under IC 8-21-12.
.6	(11) An emergency rule adopted by the insurance commissioner
7	under IC 27-1-23-7.
.8	(12) An emergency rule adopted by the Indiana horse racing
9	commission under IC 4-31-3-9.
20	(13) An emergency rule adopted by the air pollution control
21	board, the solid waste management board, or the water pollution
22	control board under IC 13-15-4-10(4) or to comply with a
23	deadline required by federal law, provided:
24	(A) the variance procedures are included in the rules; and
2.5	(B) permits or licenses granted during the period the
26	emergency rule is in effect are reviewed after the emergency
27	rule expires.
28	(14) An emergency rule adopted by the Indiana election
29	commission under IC 3-6-4.1-14.
60	(15) An emergency rule adopted by the department of natural
1	resources under IC 14-10-2-5.
32	(16) An emergency rule adopted by the Indiana gaming
33	commission under IC 4-32.2-3-3(b), IC 4-33-4-2, IC 4-33-4-3, or
34	IC 4-33-4-14.
55	(17) An emergency rule adopted by the alcohol and tobacco
66	commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or
37	IC 7.1-3-20-24.4.
8	(18) An emergency rule adopted by the department of financial
19	institutions under IC 28-15-11.
10	(19) An emergency rule adopted by the office of the secretary of
1	family and social services under IC 12-8-1-12.
12	(20) An emergency rule adopted by the office of the children's



1	health insurance program under IC 12-17.6-2-11.
2	(21) An emergency rule adopted by the office of Medicaid policy
3	and planning under IC 12-15-41-15 or IC 12-15-44-16.
4	(22) An emergency rule adopted by the Indiana state board of
5	animal health under IC 15-2.1-18-21.
6	(23) An emergency rule adopted by the board of directors of the
7	Indiana education savings authority under IC 21-9-4-7.
8	(24) An emergency rule adopted by the Indiana board of tax
9	review under IC 6-1.1-4-34 (repealed).
10	(25) An emergency rule adopted by the department of local
11	government finance under IC 6-1.1-4-33 (repealed).
12	(26) An emergency rule adopted by the boiler and pressure vessel
13	rules board under IC 22-13-2-8(c).
14	(27) An emergency rule adopted by the Indiana board of tax
15	review under IC 6-1.1-4-37(l) (repealed) or an emergency rule
16	adopted by the department of local government finance under
17	IC 6-1.1-4-36(j) (repealed) or IC 6-1.1-22.5-20.
18	(28) An emergency rule adopted by the board of the Indiana
19	economic development corporation under IC 5-28-5-8.
20	(29) A rule adopted by the department of financial institutions
21	under IC 34-55-10-2.5.
22	(30) A rule adopted by the Indiana finance authority:
23	(A) under IC 8-15.5-7 approving user fees (as defined in
24	IC 8-15.5-2-10) provided for in a public-private agreement
25	under IC 8-15.5;
26	(B) under IC $8-15-2-17.2(a)(10)$:
27	(i) establishing enforcement procedures; and
28	(ii) making assessments for failure to pay required tolls;
29	(C) under IC 8-15-2-14(a)(3) authorizing the use of and
30	establishing procedures for the implementation of the
31	collection of user fees by electronic or other nonmanual
32	means; or
33	(D) to make other changes to existing rules related to a toll
34	road project to accommodate the provisions of a
35	public-private agreement under IC 8-15.5.
36	(b) The following do not apply to rules described in subsection (a):
37	(1) Sections 24 through 36 of this chapter.
38	(2) IC 13-14-9.
39	(c) After a rule described in subsection (a) has been adopted by the
40	agency, the agency shall submit the rule to the publisher for the
41	assignment of a document control number. The agency shall submit the
42	rule in the form required by section 20 of this chapter and with the



documents required by section 21 of this chapter. The publisher shall
determine the number of copies format of the rule and other documents
to be submitted under this subsection.
(d) After the document control number has been assigned, the
agancy shall submit the rule to the manufacture of state publisher for

- (d) After the document control number has been assigned, the agency shall submit the rule to the secretary of state publisher for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The secretary of state publisher shall determine the number of copies format of the rule and other documents to be submitted under this subsection.
- (e) Subject to section 39 of this chapter, the *secretary of state publisher* shall:
 - (1) accept the rule for filing; and
 - (2) file stamp and indicate electronically record the date and time that the rule is accepted. on every duplicate original copy submitted.
- (f) A rule described in subsection (a) takes effect on the latest of the following dates:
 - (1) The effective date of the statute delegating authority to the agency to adopt the rule.
 - (2) The date and time that the rule is accepted for filing under subsection (e).
 - (3) The effective date stated by the adopting agency in the rule.
 - (4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.
- (g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in subsections (j), and (k), and (l), a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(13), (a)(24), (a)(25), or (a)(27), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. The extension period for a rule adopted under subsection (a)(28) may not exceed the period for which the original rule was in effect. A rule adopted under subsection (a)(13) may be extended for two (2) extension periods. Subject to subsection (j), a rule adopted under subsection (a)(24), (a)(25), or (a)(27) may be extended for an unlimited number of extension periods. Except for a rule adopted under subsection (a)(13), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:
 - (1) sections 24 through 36 of this chapter; or
 - (2) IC 13-14-9;







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1	as applicable.
2	(h) A rule described in subsection (a)(6), (a)(8), (a)(12), or (a)(29)
3	expires on the earlier of the following dates:
4	(1) The expiration date stated by the adopting agency in the rule.
5	(2) The date that the rule is amended or repealed by a later rule
6	adopted under sections 24 through 36 of this chapter or this
7	section.
8	(i) This section may not be used to readopt a rule under IC 4-22-2.5.
9	(j) A rule described in subsection (a)(24) or (a)(25) expires not later
10	than January 1, 2006.
11	(k) A rule described in subsection (a)(28) expires on the expiration
12	date stated by the board of the Indiana economic development
13	corporation in the rule.
14	(l) A rule described in subsection (a)(30) expires on the expiration
15	date stated by the Indiana finance authority in the rule.
16	SECTION 2. IC 12-7-2-52.5 IS ADDED TO THE INDIANA CODE
17	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
18	1, 2007]: Sec. 52.5. "Custodial parent", for purposes of
19	IC 12-15-44, has the meaning set forth in IC 12-15-44-1.
20	SECTION 3. IC 12-7-2-144.3 IS ADDED TO THE INDIANA
21	CODE AS A NEW SECTION TO READ AS FOLLOWS
22	[EFFECTIVE JULY 1, 2007]: Sec. 144.3. "Preventative care
23	services", for purposes of IC 12-15-44, has the meaning set forth in
24	IC 12-15-44-2.
25	SECTION 4. IC 12-7-2-146 IS AMENDED TO READ AS
26	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 146. "Program" refers
27	to the following:
28	(1) For purposes of IC 12-10-7, the adult guardianship services
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	program established by IC 12-10-7-5.
30	(2) For purposes of IC 12-10-10, the meaning set forth in
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	(2) For purposes of IC 12-10-10, the meaning set forth in
31	(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.
31 32	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in
31 32 33	(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5.
31 32 33 34	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in
31 32 33 34 35	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3. SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section
31 32 33 34 35 36 37 38	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3. SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is:
31 32 33 34 35 36 37 38 39	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3. SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is: (1) licensed under IC 16-21; and
31 32 33 34 35 36 37 38	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3. SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is: (1) licensed under IC 16-21; and (2) established and operated under IC 16-22-2, IC 16-22-8, or
31 32 33 34 35 36 37 38 39	 (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5. (3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5. (4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3. SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is: (1) licensed under IC 16-21; and



1	reimbursement received under section 1 of this chapter, a hospital is
2	entitled to reimbursement in an amount calculated as follows: STEP ONE: The office shall identify the aggregate inpatient
4	hospital services, reimbursable under this article and under the
5	state Medicaid plan, that were provided during the state fiscal
6	year by hospitals established and operated under IC 16-22-2,
7	IC 16-22-8, or IC 16-23.
8	STEP TWO: For the aggregate inpatient hospital services
9	identified under STEP ONE, the office shall calculate the
10	aggregate payments made under this article and under the state
11	Medicaid plan to hospitals established and operated under
12	IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under
13	IC 12-15-16, IC 12-15-17, and IC 12-15-19.
14	STEP THREE: The office shall calculate a reasonable estimate of
15	the amount that would have been paid in the aggregate by the
16	office for the inpatient hospital services described in STEP ONE
17	under Medicare payment principles.
18	STEP FOUR: Subtract the amount calculated under STEP TWO
19	from the amount calculated under STEP THREE.
20	STEP FIVE: Subject to subsection (g), from the amount
21	calculated under STEP FOUR, allocate to a hospital established
22	and operated under IC 16-22-8 an amount equal to one hundred
23	percent (100%) of the difference between:
24	(A) the total cost for the hospital's provision of inpatient
25	services covered under this article for the hospital's fiscal year
26	ending during the state fiscal year; and
27	(B) the total payment to the hospital for its provision of
28	inpatient services covered under this article for the hospital's
29	fiscal year ending during the state fiscal year, excluding
30	payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19. STEP SIX: Subtract the amount calculated under STEP FIVE
31 32	from the amount calculated under STEP FIVE
33	STEP SEVEN: Distribute an amount equal to the amount
34	calculated under STEP SIX to the eligible hospitals established
35	and operated under IC 16-22-2 or IC 16-23 described in
36	subsection (c) in proportion to each hospital's Medicaid shortfall
37	as defined in subsection (f).
38	(c) Subject to subsection (e), reimbursement for a state fiscal year
39	under this section consists of payments made after the close of each
40	state fiscal year. Payment for a state fiscal year ending after June 30,
41	2003, shall be made before December 31 following the state fiscal
12	year's and A hogaital is not aligible for a nayment described in this



subsection unless an intergovernmental transfer is made under subsection (d).

- (d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b). The office shall use the intergovernmental transfer to fund payments made under this section and as otherwise provided under IC 12-15-20-2(8). IC 12-15-20-2(6).
- (e) A hospital making an intergovernmental transfer under subsection (d) may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under STEP SEVEN of subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under STEP SEVEN of subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP SEVEN of subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.
 - (f) For purposes of this section:
 - (1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.



1	STEP THREE: The office shall calculate a reasonable estimate	
2	of the amount that would have been paid by the office for the	
3	inpatient hospital services described in STEP ONE under	
4	Medicare payment principles; and	
5	(2) a hospital's Medicaid shortfall is equal to the amount by which	
6	the amount calculated in STEP THREE of subdivision (1) is	
7	greater than the amount calculated in STEP TWO of subdivision	
8	(1).	
9	(g) The actual distribution of the amount calculated under STEP	
.0	FIVE of subsection (b) to a hospital established and operated under	
.1	IC 16-22-8 shall be made under the terms and conditions provided for	
2	the hospital in the state plan for medical assistance. Payment to a	
.3	hospital under STEP FIVE of subsection (b) is not a condition	
4	precedent to the tender of payments to hospitals under STEP SEVEN	
.5	of subsection (b).	
6	SECTION 6. IC 12-15-15-1.3 IS AMENDED TO READ AS	
.7	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.3. (a) This section	
. 8	applies to a hospital that is:	
9	(1) licensed under IC 16-21; and	
20	(2) established and operated under IC 16-22-2, IC 16-22-8, or	
2.1	IC 16-23.	
22	(b) For a state fiscal year ending after June 30, 2003, in addition to	
23	reimbursement received under section 1 of this chapter, a hospital is	
24	entitled to reimbursement in an amount calculated as follows:	
2.5	STEP ONE: The office shall identify the aggregate outpatient	
26	hospital services, reimbursable under this article and under the	
27	state Medicaid plan, that were provided during the state fiscal	
28	year by hospitals established and operated under IC 16-22-2,	
29	IC 16-22-8, or IC 16-23.	
50	STEP TWO: For the aggregate outpatient hospital services	
31	identified under STEP ONE, the office shall calculate the	
32	aggregate payments made under this article and under the state	
33	Medicaid plan to hospitals established and operated under	
54 55	IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.	
66	STEP THREE: The office shall calculate a reasonable estimate of	
57	the amount that would have been paid in the aggregate by the	
88	office under Medicare payment principles for the outpatient	
9 19	hospital services described in STEP ONE.	
10	STEP FOUR: Subtract the amount calculated under STEP TWO	
1	from the amount calculated under STEP THREE.	
12	STEP FIVE: Subject to subsection (g), from the amount	
_	Sizi firz, sasjest to sassestion (5), nom the amount	



1	calculated under STEP FOUR, allocate to a hospital established
2	and operated under IC 16-22-8 an amount equal to one hundred
3	percent (100%) of the difference between:
4	(A) the total cost for the hospital's provision of outpatient
5	services covered under this article for the hospital's fiscal year
6	ending during the state fiscal year; and
7	(B) the total payment to the hospital for its provision of
8	outpatient services covered under this article for the hospital's
9	fiscal year ending during the state fiscal year, excluding
10	payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.
11	STEP SIX: Subtract the amount calculated under STEP FIVE
12	from the amount calculated under STEP FOUR.
13	STEP SEVEN: Distribute an amount equal to the amount
14	calculated under STEP SIX to the eligible hospitals established
15	and operated under IC 16-22-2 or IC 16-23 described in
16	subsection (c) in proportion to each hospital's Medicaid shortfall
17	as defined in subsection (f).
18	(c) Subject to subsection (e), the reimbursement for a state fiscal
19	year under this section consists of payments made before December 31
20	following the end of the state fiscal year. A hospital is not eligible for
21	a payment described in this subsection unless an intergovernmental
22	transfer is made under subsection (d).
23	(d) Subject to subsection (e), a hospital may make an
24	intergovernmental transfer under this subsection, or an
25	intergovernmental transfer may be made on behalf of the hospital, after
26	the close of each state fiscal year. An intergovernmental transfer under
27	this subsection must be made to the Medicaid indigent care trust fund
28	in an amount equal to a percentage, as determined by the office, of the
29	amount to be distributed to the hospital under STEP SEVEN of
30	subsection (b). In determining the percentage, the office shall apply the
31	same percentage of not more than eighty-five percent (85%) to all
32	hospitals eligible for reimbursement under STEP SEVEN of subsection
33	(b). The office shall use the intergovernmental transfer to fund
34	payments made under this section and as otherwise provided under
35	IC 12-15-20-2(8). IC 12-15-20-2(6).
36	(e) A hospital making an intergovernmental transfer under
37	subsection (d) may appeal under IC 4-21.5 the amount determined by
38	the office to be paid by the hospital under STEP SEVEN of subsection
39	(b). The periods described in subsections (c) and (d) for the hospital to
40	make an intergovernmental transfer are tolled pending the
41	administrative appeal and any judicial review initiated by the hospital

under IC 4-21.5. The distribution to other hospitals under STEP



1	SEVEN of subsection (b) may not be delayed due to an administrative
2	appeal or judicial review instituted by a hospital under this subsection.
3	If necessary, the office may make a partial distribution to the other
4	eligible hospitals under STEP SEVEN of subsection (b) pending the
5	completion of a hospital's administrative appeal or judicial review, at
6	which time the remaining portion of the payments due to the eligible
7	hospitals must be made. A partial distribution may be calculated by the
8	office based upon estimates and trends.
9	(f) For purposes of this section:
10	(1) the Medicaid shortfall of a hospital established and operated
11	under IC 16-22-2 or IC 16-23 is calculated as follows:
12	STEP ONE: The office shall identify the outpatient hospital
13	services, reimbursable under this article and under the state
14	Medicaid plan, that were provided during the state fiscal year
15	by the hospital.
16	STEP TWO: For the outpatient hospital services identified
17	under STEP ONE, the office shall calculate the payments
18	made under this article and under the state Medicaid plan to
19	the hospital, excluding payments under IC 12-15-16,
20	IC 12-15-17, and IC 12-15-19.
21	STEP THREE: The office shall calculate a reasonable estimate
22	of the amount that would have been paid by the office for the
23	outpatient hospital services described in STEP ONE under
24	Medicare payment principles; and
25	(2) a hospital's Medicaid shortfall is equal to the amount by which
26	the amount calculated in STEP THREE of subdivision (1) is
27	greater than the amount calculated in STEP TWO of subdivision
28	(1).
29	(g) The actual distribution of the amount calculated under STEP
30	FIVE of subsection (b) to a hospital established and operated under
31	IC 16-22-8 shall be made under the terms and conditions provided for
32	the hospital in the state plan for medical assistance. Payment to a
33	hospital under STEP FIVE of subsection (b) is not a condition
34	precedent to the tender of payments to hospitals under STEP SEVEN
35	of subsection (b).
36	SECTION 7. IC 12-15-15-1.5 IS AMENDED TO READ AS
37	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.5. (a) This section
38	applies to a hospital that:
39	(1) is licensed under IC 16-21;
40	(2) is not a unit of state or local government; and
41	(3) is not owned or operated by a unit of state or local
42	government.



1	(b) For a state fiscal year ending after June 30, 2003, in addition to
2	reimbursement received under section 1 of this chapter, a hospital
3	eligible under this section is entitled to reimbursement in an amount
4	calculated as follows:
5	STEP ONE: The office shall identify the total inpatient hospital
6	services and the total outpatient hospital services, reimbursable
7	under this article and under the state Medicaid plan, that were
8	provided during the state fiscal year by the hospitals described in
9	subsection (a).
10	STEP TWO: For the total inpatient hospital services and the total
11	outpatient hospital services identified under STEP ONE, the
12	office shall calculate the aggregate payments made under this
13	article and under the state Medicaid plan to hospitals described in
14	subsection (a), excluding payments under IC 12-15-16,
15	IC 12-15-17, and IC 12-15-19.
16	STEP THREE: The office shall calculate a reasonable estimate of
17	the amount that would have been paid in the aggregate by the
18	office for the inpatient hospital services and the outpatient
19	hospital services identified in STEP ONE under Medicare
20	payment principles.
21	STEP FOUR: Subtract the amount calculated under STEP TWO
22	from the amount calculated under STEP THREE.
23	STEP FIVE: Distribute an amount equal to the amount calculated
24	under STEP FOUR to the eligible hospitals described in
25	subsection (a) as follows:
26	(A) Subject to the availability of funds under
27	$\frac{1C}{12-15-20-2(8)(D)}$ IC 12-15-20-2(6)(D) to serve as the
28	non-federal share of such payment, the first ten million dollars
29	(\$10,000,000) of the amount calculated under STEP FOUR for
30	a state fiscal year shall be paid to a hospital described in
31	subsection (a) that has more than seventy thousand (70,000)
32	Medicaid inpatient days.
33	(B) Following the payment to the hospital under clause (A)
34	and subject to the availability of funds under
35	IC 12-15-20-2(8)(D) to serve as the non-federal share of such
36	payments, the remaining amount calculated under STEP
37	FOUR for a state fiscal year shall be paid to all hospitals
38	described in subsection (a). The payments shall be made on a
39	pro rata basis based on the hospitals' Medicaid inpatient days
40	or other payment methodology approved by the Centers for
41	Medicare and Medicaid Services.
42	(C) Subject to IC 12-15-20.7, in the event the entirety of the



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1	amount calculated under STEP FOUR is not distributed
2	following the payments made under clauses (A) and (B), the
3	remaining amount may be paid to hospitals described in
4	subsection (a) that are eligible under this clause. A hospital is
5	eligible for a payment under this clause only if the non-federal
6	share of the hospital's payment is provided by or on behalf of
7	the hospital. The remaining amount shall be paid to those
8	eligible hospitals on a pro rata basis in relation to all hospitals
9	eligible under this clause based on the hospitals' Medicaid
10	inpatient days or other payment methodology approved by the
11	Centers for Medicare and Medicaid Services.
12	(D) For purposes of the clauses (A), (B) and (C), a hospital's
13	Medicaid inpatient days are based on the Medicaid inpatient
14	days allowed for the hospital by the office for purposes of the
15	office's most recent determination of eligibility for the
16	Medicaid disproportionate payment program under
17	IC 12-15-16.
18	(c) Reimbursement for a state fiscal year under this section consists

- (c) Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.
- (d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of subsection (b). The distribution to other hospitals under STEP FIVE of subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

SECTION 8. IC 12-15-15-9.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

- (1) who is a resident of the county;
- (2) who is not a resident of the county and for whom the onset of



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1 2	the medical condition that necessitated the care occurred in the county; or	
3	(3) whose residence cannot be determined by the division and for	
4	whom the onset of the medical condition that necessitated the care	
5	occurred in the county.	
6	(b) For each state fiscal year ending after June 30, 2003, a hospital	
7	licensed under IC 16-21-2:	
8	(1) that submits to the division during the state fiscal year a	
9	payable claim under IC 12-16-7.5; and	
0	(2) whose payment under section 9(c) of this chapter was less	
1	than the total amount of the hospital's payable claims under	
2	IC 12-16-7.5 submitted by the hospital to the division during the	
3	state fiscal year;	
4	is entitled to a payment under this section.	
.5	(c) Except as provided in section 9.8 of this chapter and subject to	
6	section 9.6 of this chapter, for a state fiscal year, the office shall pay to	-
7	a hospital referred to in subsection (b) an amount equal to the amount,	
.8	based on information obtained from the division and the calculations	
9	and allocations made under IC 12-16-7.5-4.5, that the office determines	
20	for the hospital under STEP EIGHT of the following STEPS:	
21	STEP ONE: Identify each county whose transfer of funds to the	
22	Medicaid indigent care trust fund under STEP FOUR of	
23	IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total	
24	amount of all hospital payable claims attributed to the county and	
25	submitted to the division during the state fiscal year.	
26	STEP TWO: For each county identified in STEP ONE, calculate	_
27	the difference between the amount of funds of the county	\
28	transferred to the Medicaid indigent care trust fund under STEP	
29	FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital	1
0	payable claims attributed to the county and submitted to the	
51	division during the state fiscal year.	
32	STEP THREE: Calculate the sum of the amounts calculated for	
3	the counties under STEP TWO.	
34	STEP FOUR: Identify each hospital whose payment under section	
35	9(c) of this chapter was less than the total amount of the hospital's	
66	payable claims under IC 12-16-7.5 submitted by the hospital to	
57	the division during the state fiscal year.	
8	STEP FIVE: Calculate for each hospital identified in STEP FOUR	
19	the difference between the hospital's payment under section 9(c)	
10	of this chapter and the total amount of the hospital's payable	
-1	claims under IC 12-16-7.5 submitted by the hospital to the	



division during the state fiscal year.

1	STEP SIX: Calculate the sum of the amounts calculated for each
2	of the hospitals under STEP FIVE.
3	STEP SEVEN: For each hospital identified in STEP FOUR,
4	calculate the hospital's percentage share of the amount calculated
5	under STEP SIX. Each hospital's percentage share is based on the
6	amount calculated for the hospital under STEP FIVE calculated
7	as a percentage of the sum calculated under STEP SIX.
8	STEP EIGHT: For each hospital identified in STEP FOUR,
9	multiply the hospital's percentage share calculated under STEP
10	SEVEN by the sum calculated under STEP THREE. The amount
11	calculated under this STEP for a hospital may not exceed the
12	amount by which the hospital's total payable claims under
13	IC 12-16-7.5 submitted during the state fiscal year exceeded the
14	amount of the hospital's payment under section 9(c) of this
15	chapter.
16	(d) A hospital's payment under subsection (c) is in the form of a
17	Medicaid add-on payment. The amount of the hospital's add-on
18	payment is subject to the availability of funding for the non-federal
19	share of the payment under subsection (e). The office shall make the
20	payments under subsection (c) before December 15 that next succeeds
21	the end of the state fiscal year.
22	(e) The non-federal share of a payment to a hospital under
23	subsection (c) is derived from funds transferred to the Medicaid
24	indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and
25	not expended under section 9 of this chapter. To the extent possible,
26	the funds shall be derived on a proportional basis from the funds
27	transferred by each county identified in subsection (c), STEP ONE:
28	(1) to which at least one (1) payable claim submitted by the
29	hospital to the division during the state fiscal year is attributed;
30	and
31	(2) whose funds transferred to the Medicaid indigent care trust
32	fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not
33	completely expended under section 9 of this chapter.
34	The amount available to be derived from the remaining funds
35	transferred to the Medicaid indigent care trust fund under STEP FOUR
36	of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment
37	to a hospital under subsection (c) is an amount that bears the same
38	proportion to the total amount of funds transferred by all the counties
39	identified in subsection (c), STEP ONE, that the amount calculated for
40	the hospital under subsection (c), STEP FIVE, bears to the amount



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calculated under subsection (c), STEP SIX.

(f) Except as provided in subsection (g), the office may not make a

1	payment under this section until the payments due under section 9 of
2	this chapter for the state fiscal year have been made.
3	(g) If a hospital appeals a decision by the office regarding the
4	hospital's payment under section 9 of this chapter, the office may make
5	payments under this section before all payments due under section 9 of
6	this chapter are made if:
7	(1) a delay in one (1) or more payments under section 9 of this
8	chapter resulted from the appeal; and
9	(2) the office determines that making payments under this section
0	while the appeal is pending will not unreasonably affect the
1	interests of hospitals eligible for a payment under this section.
2	(h) Any funds transferred to the Medicaid indigent care trust fund
.3	under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments
.4	are made under this section shall be used as provided in
.5	IC 12-15-20-2(8)(D). IC 12-15-20-2(6)(D).
.6	(i) For purposes of this section:
.7	(1) "payable claim" has the meaning set forth in
. 8	IC 12-16-7.5-2.5(b);
.9	(2) the amount of a payable claim is an amount equal to the
20	amount the hospital would have received under the state's
21	fee-for-service Medicaid reimbursement principles for the
22	hospital care for which the payable claim is submitted under
23	IC 12-16-7.5 if the individual receiving the hospital care had been
24	a Medicaid enrollee; and
25	(3) a payable hospital claim under IC 12-16-7.5 includes a
26	payable claim under IC 12-16-7.5 for the hospital's care submitted
27 28	by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.
.6 29	SECTION 9. IC 12-15-15-9.8 IS AMENDED TO READ AS
30	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.8. (a) This section
1	applies only if the office determines, based on information received
32	from the United States Centers for Medicare and Medicaid Services,
33	that a state Medicaid plan amendment implementing the payment
34	methodology in:
55	(1) section 9(c) of this chapter; or
6	(2) section 9.5(c) of this chapter;
37	will not be approved by the United States Centers for Medicare and
8	Medicaid Services.
9	(b) The office may amend the state Medicaid plan to implement an
10	alternative payment methodology. to the payment methodology under
1	section 9 of this chapter. The alternative payment methodology must
12	provide each hospital that would have received a payment under



1	section 9(c) of this chapter during a state fiscal year with an amount for
2	the state fiscal year that is as equal as possible to the amount each
3	hospital would have received under the payment methodology under
4	section 9(c) of this chapter. A payment methodology implemented
5	under this subsection is in place of the payment methodology under
6	section 9(c) of this chapter.
7	(c) The office may amend the state Medicaid plan to implement an
8	alternative payment methodology to the payment methodology under
9	section 9.5 of this chapter. The alternative payment methodology must
10	provide each hospital that would have received a payment under
11	section 9.5(c) of this chapter during a state fiscal year with an amount
12	for the state fiscal year that is as equal as possible to the amount each
13	hospital would have received under the payment methodology under
14	section 9.5(c) of this chapter. A payment methodology implemented
15	under this subsection is in place of the payment methodology under
16	section 9.5(c) of this chapter.
17	SECTION 10. IC 12-15-15-10 IS AMENDED TO READ AS
18	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) This section
19	applies to a hospital that:
20	(1) is licensed under IC 16-21; and
21	(2) qualifies as a provider under the Medicaid disproportionate
22	share provider program.
23	(b) The office may, after consulting with affected providers, do one
24	(1) or more of the following:
25	(1) Expand the payment program established under section 1.1(b)
26	of this chapter to include all hospitals described in subsection (a).
27	(2) (1) Establish a nominal charge hospital payment program.
28	(3) (2) Establish any other permissible payment program.
29	(c) A program expanded or established under this section is subject
30	to the availability of:
31	(1) intergovernmental transfers; or
32	(2) funds certified as being eligible for federal financial
33	participation.
34	(d) The office may not implement a program under this section until
35	the federal Centers for Medicare and Medicaid Services approves the
36	provisions regarding the program in the amended state plan for medical
37	assistance.
38	(e) The office may determine not to continue to implement a
39	program established under this section if federal financial participation
40	is not available.

SECTION 11. IC 12-15-19-8 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 8. (a) A provider that



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qualifies as a municipal disproportionate share provider under IC 12-15-16-1 shall receive a disproportionate share adjustment, subject to the provider's hospital specific limits described in subsection (b), as follows:

- (1) For each state fiscal year ending on or after June 30, 1998, an amount shall be distributed to each provider qualifying as a municipal disproportionate share provider under IC 12-15-16-1. The total amount distributed shall not exceed the sum of all hospital specific limits for all qualifying providers.
- (2) For each municipal disproportionate share provider qualifying under IC 12-15-16-1 to receive disproportionate share payments, the amount in subdivision (1) shall be reduced by the amount of disproportionate share payments received by the provider under IC 12-15-16-6 or sections 1 or 2.1 of this chapter. The office shall develop a disproportionate share provider payment methodology that ensures that each municipal disproportionate share provider receives disproportionate share payments that do not exceed the provider's hospital specific limit specified in subsection (b). The methodology developed by the office shall ensure that a municipal disproportionate share provider receives, to the extent possible, disproportionate share payments that, when combined with any other disproportionate share payments owed to the provider, equals the provider's hospital specific limits.
- (b) Total disproportionate share payments to a provider under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for state fiscal years ending on or before June 30, 1999, shall be determined by the office taking into account data provided by each hospital for the hospital's most recent fiscal year or, if a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data compiled to the end of the provider's fiscal year that ends within the most recent state fiscal year, as certified to the office by an independent certified public accounting firm. The hospital specific limit for all state fiscal years ending on or after June 30, 2000, shall be determined by the office taking into account data provided by each hospital that is deemed reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.
 - (c) For each of the state fiscal years:
 - (1) beginning July 1, 1998, and ending June 30, 1999; and











1	(2) beginning July 1, 1999, and ending June 30, 2000;
2	the total municipal disproportionate share payments available under
3	this section to qualifying municipal disproportionate share providers is
4	twenty-two million dollars (\$22,000,000).
5	(d) For each of the state fiscal years ending after June 30, 2006,
6	the total municipal disproportionate share payments available
7	under this section to qualifying municipal disproportionate share
8	providers is forty million dollars (\$40,000,000).
9	SECTION 12. IC 12-15-20-2 IS AMENDED TO READ AS
10	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. The Medicaid
11	indigent care trust fund is established to pay the non-federal share of
12	the following:
13	(1) Enhanced disproportionate share payments to providers under
14	IC 12-15-19-1.
15	(2) Subject to subdivision (8), disproportionate share payments to
16	providers under IC 12-15-19-2.1.
17	(3) Medicaid payments for pregnant women described in
18	IC 12-15-2-13 and infants and children described in
19	IC 12-15-2-14.
20	(4) Municipal disproportionate share payments to providers under
21	IC 12-15-19-8.
22	(5) Payments to hospitals under IC 12-15-15-9.
23	(6) Payments to hospitals under IC 12-15-15-9.5.
24	(7) (5) Payments, funding, and transfers as otherwise provided in
25	clauses (8)(D) and (8)(F).
26	(8) (6) Of the intergovernmental transfers deposited into the
27	Medicaid indigent care trust fund, the following apply:
28	(A) The entirety of the intergovernmental transfers deposited
29	into the Medicaid indigent care trust fund for state fiscal years
30	ending on or before June 30, 2000, shall be used to fund the
31	state's share of the disproportionate share payments to
32	providers under IC 12-15-19-2.1.
33	(B) Of the intergovernmental transfers deposited into the
34	Medicaid indigent care trust fund for the state fiscal year
35	ending June 30, 2001, an amount equal to one hundred percent
36	(100%) of the total intergovernmental transfers deposited into
37	the Medicaid indigent care trust fund for the state fiscal year
38	beginning July 1, 1998, and ending June 30, 1999, shall be
39	used to fund the state's share of disproportionate share
40	payments to providers under IC 12-15-19-2.1. The remainder
41	of the intergovernmental transfers, if any, for the state fiscal
42	year shall be used to fund the state's share of additional



1	Medicaid payments to hospitals licensed under IC 16-21	
2	pursuant to a methodology adopted by the office.	
3	(C) Of the intergovernmental transfers deposited into the	
4	Medicaid indigent care trust fund, for state fiscal years	
5	beginning July 1, 2001, and July 1, 2002, an amount equal to:	
6	(i) one hundred percent (100%) of the total	
7	intergovernmental transfers deposited into the Medicaid	
8	indigent care trust fund for the state fiscal year beginning	
9	July 1, 1998; minus	
10	(ii) an amount equal to the amount deposited into the	
11	Medicaid indigent care trust fund under IC 12-15-15-9(d)	
12	(before its repeal) for the state fiscal years beginning July	
13	1, 2001, and July 1, 2002;	
14	shall be used to fund the state's share of disproportionate share	
15	payments to providers under IC 12-15-19-2.1. The remainder	
16	of the intergovernmental transfers, if any, must be used to fund	
17	the state's share of additional Medicaid payments to hospitals	
18	licensed under IC 16-21 pursuant to a methodology adopted by	
19	the office.	
20	(D) Of the intergovernmental transfers, which shall include	
21	amounts transferred under IC 12-16-7.5-4.5(b), STEP FOUR,	
22	deposited into the Medicaid indigent care trust fund for state	
23	fiscal years ending after June 30, 2003, an amount equal to:	
24	(i) one hundred percent (100%) of the total	
25	intergovernmental transfers deposited into the Medicaid	
26	indigent care trust fund for the state fiscal year beginning	
27	July 1, 1998, and ending June 30, 1999; minus	
28	(ii) an amount equal to the amount deposited into the	V
29	Medicaid indigent care trust fund under STEP FOUR of	
30	IC 12-16-7.5-4.5(b) for the state fiscal year ending after June	
31	30, 2003;	
32	shall be used to fund the non-federal share of disproportionate	
33	share payments to providers under IC 12-15-19-2.1. The	
34	remainder of the intergovernmental transfers, if any, for the	
35	state fiscal years shall be used to fund, in descending order of	
36	priority, the non-federal share of payments to hospitals under	
37	IC 12-15-15-9, the non-federal share of payments to hospitals	
38	under IC 12-15-15-9.5, the amount to be transferred under	
39	clause (F), and the non-federal share of payments under	
40	clauses (A) and (B) of STEP FIVE of IC 12-15-1.5(b).	
41	(E) The total amount of intergovernmental transfers used to	
42	fund the non-federal share of payments to hospitals under	
	* *	



1	IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the
2	amount calculated under STEP TWO of the following formula:
3	STEP ONE: Calculate the total amount of funds transferred to
4	the Medicaid indigent care trust fund under STEP FOUR of
5	IC 12-16-7.5-4.5(b).
6	STEP TWO: Multiply the state Medicaid medical assistance
7	percentage for the state fiscal year for which the payments
8	under IC 12-15-15-9 and IC 12-15-15-9.5 are to be made by
9	the amount calculated under STEP ONE.
10	(F) (E) As provided in clause (D), for each fiscal year ending
11	after June 30, 2003, but before July 1, 2006, an amount equal
12	to the amount calculated under STEP THREE of the following
13	formula shall be transferred to the office:
14	STEP ONE: Calculate the product of thirty-five million dollars
15	(\$35,000,000) multiplied by the federal medical assistance
16	percentage for federal fiscal year 2003.
17	STEP TWO: Calculate the sum of the amounts, if any,
18	reasonably estimated by the office to be transferred or
19	otherwise made available to the office for the state fiscal year,
20	and the amounts, if any, actually transferred or otherwise made
21	available to the office for the state fiscal year, under
22	arrangements whereby the office and a hospital licensed under
23	IC 16-21-2 agree that an amount transferred or otherwise made
24	available to the office by the hospital or on behalf of the
25	hospital shall be included in the calculation under this STEP.
26	STEP THREE: Calculate the amount by which the product
27	calculated under STEP ONE exceeds the sum calculated under
28	STEP TWO.
29	(F) For each fiscal year ending after June 30, 2006, the
30	entirety of the intergovernmental transfers deposited into
31	the Medicaid indigent care trust fund shall be used for
32	Medicaid supplemental payments, disproportionate share
33	payments, and the transfer of twenty-eight million dollars
34	(\$28,000,000) to the office for the Medicaid budget.
35	SECTION 13. IC 12-15-20.7-2 IS AMENDED TO READ AS
36	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. For each state fiscal
37	year, subject to section 3 of this chapter, the office shall make the
38	payments identified in this section in the following order:
39	(1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.
40	(2) Second, (1) First, payments under clauses (A) and (B) of
41	STEP FIVE of IC 12-15-1.5(b).
42	(3) Third, (2) Second, Medicaid inpatient payments for safety-net
	, , , , , , , , , , , , , , , , , , ,



1	hospitals and Medicaid outpatient payments for safety-net
2	hospitals.
3	(4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.
4	(5) Fifth, (3) Third, payments under IC 12-15-19-8 for municipal
5	disproportionate share hospitals.
6	(6) Sixth, (4) Fourth, payments under IC 12-15-19-2.1 for
7	disproportionate share hospitals.
8	(7) Seventh, payments under clause (C) of STEP FIVE of
9	IC 12-15-15-1.5(b).
0	SECTION 14. IC 12-15-44 IS ADDED TO THE INDIANA CODE
1	AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
2	JULY 1, 2007]:
3	Chapter 44. Healthier Indiana Insurance Program
4	Sec. 1. As used in this chapter, "custodial parent" means the
5	individual with whom a child resides and who is related to the child
6	in one (1) of the following manners:
7	(1) Legal or biological mother.
8	(2) Legal or biological father.
9	(3) A blood relative within the fifth degree of relation,
0	including an individual who is related by half blood.
1	(4) Stepfather, stepmother, stepbrother, or stepsister.
2	(5) An individual who legally adopts a child or the child's
3	parent, as well as relatives of the adoptive parents.
4	(6) Legal spouses of an individual described in this subsection.
5	Sec. 2. As used in this chapter, "preventative care services"
6	means care that is provided to an individual for the purpose of
7	preventing disease, diagnosing disease, or promoting good health.
8	Sec. 3. As used in this chapter, "program" refers to the
9	healthier Indiana insurance program established by IC 12-15-44-4.
0	Sec. 4. (a) The healthier Indiana insurance program is
1	established.
2	(b) The office shall administer the program.
3	(c) The following requirements apply to funds appropriated by
4	the general assembly to the program:
5	(1) At least ninety percent (90%) must be used to fund
6	payment for health care services.
7	(2) Not more than ten percent (10%) may be used to fund:
8	(A) administrative costs; and
9	(B) any profit derived from a contract entered into by a
·0 ·1	person to provide services for the program. Sec. 5. (a) An individual is eligible for the program if the
2	individual meets the following requirements:
<u>~</u>	murrada meets the following fequilements.



1	(1) The individual is at least eighteen (18) years of age and less	
2	than sixty-five (65) years of age.	
3	(2) The individual is a United States citizen and has been a	
4	resident of Indiana for at least twelve (12) months.	
5	(3) The individual has an annual household income of:	
6	(A) not more than two hundred percent (200%) of the	
7	federal income poverty level if the individual is a custodial	
8	parent; or	
9	(B) at least one hundred percent (100%) and not more	
10	than two hundred percent (200%) of the federal income	1
11	poverty level if the individual is not a custodial parent.	
12	(4) The individual is not eligible for health insurance coverage	,
13	through the individual's employer.	
14	(5) The individual has not had health insurance coverage for	
15	at least six (6) months.	
16	(b) The following individuals are not eligible for this program:	4
17	(1) An individual who participates in the federal Medicare	
18	program (42 U.S.C. 1395 et seq.).	
19	(2) A pregnant woman for purposes of pregnancy related	
20	services.	
21	(3) An individual who is eligible for the Medicaid program as	
22	a disabled person.	
23	Sec. 6. (a) In order to participate in the program, an individual	
24	shall do the following:	
25	(1) Apply for the program on a form prescribed by the office.	
26	The office may develop and allow a joint application for a	
27	household.	
28	(2) If the individual is approved by the office to participate in	,
29	the program, contribute to the individual's health care	
30	account:	
31	(A) at least one thousand one hundred dollars (\$1,100) per	
32	year, but not more than five percent (5%) of the	
33	individual's annual household income; or	
34	(B) one thousand one hundred dollars (\$1,100) per year	
35	less the individual's contributions to the Medicaid program	
36	under IC 12-15, the children's health insurance program	
37	under IC 12-17.6, or the Medicare program (42 U.S.C.	
38	1395 et seq.), as determined by the office.	
39	(b) The state shall contribute the difference into the individual's	
40	account if the individual's contribution of five percent (5%) of the	
41	individual's annual income is less than the required one thousand	
42	one hundred dollars (\$1,100).	



1	(c) If the individual does not make the individual's contributions	
2	to the program within thirty (30) days of the required payment, the	
3	individual may be terminated from participating in the program.	
4	The individual shall receive written notice before the individual is	
5	terminated from the program.	
6	(d) After termination from the program under subsection (c),	
7	the individual may not reapply to participate in the program for	
8	eighteen (18) months.	
9	(e) An individual may be held responsible under the program	
10	for receiving nonemergency services in an emergency room setting.	
11	This may include requiring the individual to pay for services	
12	received in the emergency room with money outside the	
13	individual's health care account.	
14	Sec. 7. (a) A participant must have a health care account in	
15	which contributions are made by the participant, an employer, or	
16	the office.	
17	(b) The minimum amount in the account is the amount	
18	contributed by the individual and the state as described in section	
19	6 of this chapter.	
20	(c) The account is to be used for paying the individual's	
21	deductible for health care services in the program.	
22	(d) The individual may contribute to the individual's health care	
23	account through the following means:	
24	(1) By the employer withholding or causing to be withheld	
25	from the participating employee's wages or salary, after taxes	
26	are taken out of the wages or salary, the participating	
27	employee's required share described in this chapter and	
28	distributed equally throughout the calendar year.	
29	(2) By submitting the individual's required share to the office	
30	to deposit into the individual's account in a manner	
31	prescribed by the office.	
32	(3) Any other means determined by the office.	
33	Sec. 8. (a) The program must cover preventative care services,	
34	as determined by the office, for a participant of not more than five	
35	hundred dollars (\$500) per year. This amount shall be paid by the	
36	state at no cost to the participant.	
37	(b) The office shall provide a participant with a list of health	
38	care services that will qualify as preventative care services for the	
39	age, gender, and preexisting conditions of the participant. The	
40	office shall consult the federal Centers for Disease Control and	
41	Prevention for a list of recommended preventative care services.	
12	Sec. 9. (a) The office shall determine the health care services	



1	covered under the program.
2	(b) The program is not an entitlement program, and the number
3	of individuals who may participate in the program is dependent
4	upon the funds appropriated for use for the plan.
5	Sec. 10. The program has the following per recipient coverage
6	limitations:
7	(1) An annual individual maximum coverage limitation of
8	three hundred thousand dollars (\$300,000).
9	(2) A lifetime individual maximum coverage of one million
10	dollars (\$1,000,000).
11	Sec. 11. (a) An individual who is approved to participate in the
12	program is eligible for a twelve (12) month period. Once the
13	individual has been approved for participation, the individual may
14	not be turned down for renewal into the program for the sole
15	reason that the program has reached the maximum number of
16	participants.
17	(b) If the individual chooses to renew participation in the
18	program, the individual shall complete a renewal application, any
19	necessary documentation, and submit the documentation and
20	application on a form prescribed by the office to the office in order
21	to continue participating in the program.
22	(c) If the individual chooses not to renew participation in the
23	program, the individual may not reapply to participate in the
24	program for at least eighteen (18) months.
25	Sec. 12. An insurer or health maintenance organization that has
26	contracted with the office to provide health insurance for
27	individuals under this program:
28	(1) bears the risk of the health insurance program;
29	(2) is responsible for the claim processing under the program;
30	(3) shall reimburse providers at a reimbursement rate of:
31	(A) at least the federal Medicare reimbursement rate for
32	the service provided; or
33	(B) at a rate of one hundred thirty percent (130%) of the
34	Medicaid reimbursement rate for a service that does not
35	have a Medicare reimbursement rate; and
36	(4) may not deny coverage to an eligible individual who has
37	been approved by the office to participate in the program,
38	except if the maximum coverage rates are met as described in
39	section 10 of this chapter.
40	Sec. 13. (a) A participant in the program has coverage for a
41	period of twelve (12) months. If the participant would like to

 $continue\ participating\ in\ the\ program, the\ participant\ must\ submit$



1	an application for renewal with the office as required in section 11
2	of this chapter.
3	(b) At the end an individual's twelve (12) month program
4	period, and if the individual's health care account contains a
5	balance of more than five hundred dollars (\$500), the individual
6	may withdraw the money that exceeds five hundred dollars (\$500)
7	from the account if the criteria specified in subsection (c) are met.
8	(c) The individual may only withdraw money from the
9	individual's health care account if the following criteria are met:
10	(1) The account has more than five hundred dollars (\$500)
11	remaining.
12	(2) The money being withdrawn is money that the individual,
13	not the state, contributed to the account and may not exceed
14	the total of the individual's contribution. The office shall
15	determine this amount by prorating the remaining amount
16	with the amount contributed by the individual.
17	(3) The individual has completed the individual's preventative
18	care services.
19	(4) The money is used to pay for dental services or vision
20	services that are not covered under the program's plan.
21	(d) Money remaining in the account at the end of the
22	individual's twelve (12) month period that is not withdrawn as
23	allowed under subsection (c):
24	(1) remains in the account if the individual renews
25	participation in the program and the amount the individual
26	needs to contribute to the account in the following program
27	year is prorated based on the amount remaining in the
28	account; or
29	(2) is forfeited by the individual and reverts back to the state
30	if the individual:
31	(A) does not continue to participate in the program; or
32	(B) is terminated from the program under section 6 of this
33	chapter.
34	Sec. 14. (a) The healthier Indiana insurance fund is established
35	for the following purposes:
36	(1) Administering a program created by the general assembly
37	to provide health insurance for low income residents of the
38	state under this chapter.
39	(2) Providing copayments, preventative care services, and
10	premiums for individuals enrolled in the program.
4 1	(3) Funding tobacco use prevention and cessation programs
12	and programs designed to promote the general health and



1	well being of Indiana residents.	
2	(4) Promoting research in the health and life sciences field,	
3	including grants to universities for operating and capital	
4	expenses.	
5	The fund is apart from the state general fund.	
6	(b) The fund shall be administered by the office of the secretary	
7	of family and social services.	
8	(c) The expenses of administering the fund shall be paid from	
9	money in the fund.	
10	(d) The fund shall consist of the following:	
11	(1) Cigarette tax revenues designated by the general assembly	
12	to be part of the fund.	
13	(2) Other funds designated by the general assembly to be part	
14	of the fund.	
15	(3) Federal funds available for the purposes of the fund.	
16	(4) Gifts or donations to the fund.	
17	(e) Money from each source going into the fund must be placed	
18	into a separate account within the fund. Any unencumbered	
19	balance in an account at the end of the state fiscal year that was	
20	previously used for another program but diverted for use in this	
21	program must be transferred back to the previous program.	
22	(f) The treasurer of state shall invest the money in the fund not	
23	currently needed to meet the obligations of the fund in the same	
24	manner as other public money may be invested.	
25	(g) Money must be appropriated before funds are available for	
26	use.	
27	(h) Money in the fund does not revert to the state general fund	
28	at the end of any fiscal year.	V
29	Sec 15. (a) The office may not:	
30	(1) enroll applicants;	
31	(2) approve any contracts with vendors to provide services or	
32	administer the program;	
33	(3) incur costs other than those necessary to study and plan	
34	for the implementation of the program; or	
35	(4) create financial obligations for the state;	
36	unless there is a specific appropriation from the general assembly	
37	to implement the program.	
38	(b) The office may not operate the program in a way that would	
39	obligate the state to financial participation beyond the level of state	
40 4.1	appropriations authorized for this purpose.	
41 12	(c) The office shall: (1) modify limitations on participation:	
. /	t i magity limitations an narticination:	



1	(2) modify services provided;
2	(3) establish or modify copayments; or
3	(4) otherwise limit program expansion;
4	in order to manage the program within the spending authorized by
5	the general assembly.
6	Sec. 16. The office may adopt rules under IC 4-22-2 necessary
7	to implement this chapter. The office may adopt emergency rules
8	under IC 4-22-2-37.1 to implement the program on an emergency
9	basis.
0	SECTION 15. IC 12-16-5.5-1.2, AS ADDED BY P.L.145-2005,
1	SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
2	JULY 1, 2007]: Sec. 1.2. (a) The division shall, upon receipt of a claim
.3	pertaining to a person:
4	(1) who was admitted to, or who was otherwise provided care by, a hospital; and
.6	(2) whose medical condition satisfies one (1) or more of the
.7	medical conditions identified in IC 12-16-3.5-1(a)(1) through
. 8	IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through
9	IC 12-16-3.5-2(a)(3);
20	promptly review the claim to determine if the health care items or
.0 21	services identified in the claim were necessitated by the person's
22	medical condition or, if applicable, if the items or services were a direct
23	consequence of the person's medical condition.
24	(b) In conducting the review of a claim referenced in subsection (a),
2.5	the division shall calculate the amount of the claim. For purposes of
26	this section, IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-6.5, and
27	IC 12-16-7.5, the amount of a claim shall be calculated in a manner
28	described in IC 12-16-7.5-2.5(c).
29	SECTION 16. IC 12-16-7.5-1.2, AS ADDED BY P.L.145-2005,
0	SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
31	JULY 1, 2007]: Sec. 1.2. (a) A person determined to be eligible under
32	the hospital care for the indigent program is not financially obligated
3	for hospital items or services, physician services, or transportation
4	services provided to the person during the person's eligibility under the
55	program, if the items or services were:
6	(1) identified in a claim filed with the division under
37	IC 12-16-4.5; and
8	(2) determined:
19	(A) to have been necessitated by one (1) or more of the
10	medical conditions listed in IC 12-16-3.5-1(a)(1) through
1	IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through
12	IC 12-16-3.5-2(a)(3); or



medical conditions listed in IC 12-16-3.5-1(a)(1) throug IC 12-16-3.5-1(a)(3). (b) Based on a hospital's items or services identified in a clain under subsection (a); the hospital may receive a payment from the office calculated and made under IC 12-15-15-9 and; if applicable IC 12-15-15-9.5. (c) (b) Based on a physician's services identified in a clain under subsection (a), the physician may receive a payment from the division calculated and made under section 5 of this chapter. (d) (e) Based on the transportation services identified in a clain under subsection (a), the transportation services identified in a clain under subsection (a), the transportation services identified in a clain under subsection (a), the transportation provider may receive payment from the division calculated and made under section 5 of the chapter. SECTION 17. IC 12-16-7.5-2.5, AS AMENDED BY P.L.1-2006 SECTION 189, IS AMENDED TO READ AS FOLLOW [EFFECTIVE JULY 1, 2007]: Sec. 2.5. (a) Payable claims shall be segregated by state fiscal year. (b) For purposes of this chapter IC 12-15-15-9, IC 12-15-15-9.5, an IC 12-16-14, "payable claim" refers to the following: (1) Subject to subdivision (2), a claim for payment for physicial care, hospital care through June 30, 2005, or transportation services under this chapter: (A) that includes, on forms prescribed by the division, all the information required for timely payment; (B) that is for a period during which the person is determined to be financially and medically eligible for the hospital care for the indigent program; and (C) for which the payment amounts for the care and service are determined by the division. This subdivision applies for the state fiscal year ending June 30, 2004. (2) For state fiscal years ending after June 30, 2004, a claim for payment for physician care, hospital care through June 30, 2006 or transportation services under this chapter: (A) provided to a person under the hospital care for the indigent program under this article during the person eligibility			
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1	IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through	
2	IC 12-16-3.5-2(a)(3); or	
3	(ii) be a direct consequence of one (1) or more of the	
4	medical conditions listed in IC 12-16-3.5-1(a)(1) through	
5	IC 12-16-3.5-1(a)(3).	
6	(c) For purposes of this chapter IC 12-15-15-9, IC 12-15-15-9.5, and	
7	IC 12-16-14, "amount" when used in regard to a claim or payable claim	
8	means an amount calculated under STEP THREE of the following	
9	formula:	
10	STEP ONE: Identify the items and services identified in a	- 1
11	claim or payable claim.	
12	STEP TWO: Using the applicable Medicaid fee for service	
13	reimbursement rates, calculate the reimbursement amounts for	
14	each of the items and services identified in STEP ONE.	
15	STEP THREE: Calculate the sum of the amounts identified in	
16	STEP TWO.	(
17	(d) For purposes of this chapter IC 12-15-15-9, IC 12-15-15-9.5, and	,
18	IC 12-16-14, a physician, hospital through June 30, 2005, or	
19	transportation provider that submits a claim to the division is	
20	considered to have submitted the claim during the state fiscal year	
21	during which the amount of the claim was determined under	
22	IC 12-16-5.5-1.2(b) or, if successfully appealed by a physician,	
23	hospital, or transportation provider, the state fiscal year in which the	
24	appeal was decided.	-
25	(e) The division shall determine the amount of a claim under	
26	IC 12-16-5.5-1.2(b).	_
27	SECTION 18. IC 12-16-7.5-3 IS AMENDED TO READ AS	\
28	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) A payment made	
29	to a physician or a transportation provider under this chapter must be	
30	on a warrant drawn on the state hospital care for the indigent fund	
31	established by IC 12-16-14.	
32	(b) A payment made to a hospital under this chapter shall be made	
33	under IC 12-15-15-9 and IC 12-15-15-9.5.	
34	SECTION 19. IC 12-16-7.5-4.5 IS AMENDED TO READ AS	
35	FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) Not later than	
36	October 31 following the end of each state fiscal year, the division	
37	shall:	
38	(1) calculate for each county the total amount of payable claims	
39	submitted to the division during the state fiscal year attributed to:	
40	(A) patients who were residents of the county; and	
41	(B) patients:	
42	(i) who were not residents of Indiana;	



1	(ii) whose state of residence could not be determined by the
2	division; and
3	(iii) who were residents of Indiana but whose county of
4	residence in Indiana could not be determined by the
5	division;
6	and whose medical condition that necessitated the care or
7	service occurred in the county;
8	(2) notify each county of the amount of payable claims attributed
9	to the county under the calculation made under subdivision (1);
0	and
. 1	(3) with respect to payable claims attributed to a county under
2	subdivision (1):
3	(A) calculate the total amount of payable claims submitted
4	during the state fiscal year for:
.5	(i) each hospital;
.6	(ii) each physician; and
.7	(iii) each transportation provider; and
. 8	(B) determine the amount of each payable claim for each
9	hospital, physician, and transportation provider listed in clause
20	(A).
21	(b) Except as provided in subsection (c), before November 1
22	following the end of a state fiscal year, the division shall allocate the
23	funds transferred from a county's hospital care for the indigent fund to
24	the state hospital care for the indigent fund under IC 12-16-14 during
25	or for the state fiscal year as required under the following STEPS:
26	STEP ONE: Determine the total amount of funds transferred from
27	a county's hospital care for the indigent fund by the county to the
28	state hospital care for the indigent fund under IC 12-16-14 during
29	or for the state fiscal year.
0	STEP TWO: Of the total amount of payable claims submitted to
31	the division during the state fiscal year attributed to the county
32	under subsection (a), determine the amount of total hospital
33	payable claims, total physician payable claims, and total
34	transportation provider payable claims. Of the amounts
55	determined for physicians and transportation providers, calculate
66	the sum of those amounts as a percentage of an amount equal to
37	the sum of the total payable physician claims and total payable
8	transportation provider claims attributed to all the counties
9	submitted to the division during the state fiscal year.
10	STEP THREE: Multiply three million dollars (\$3,000,000) by the
1	percentage calculated under STEP TWO.
-2	STEP FOUR: Transfer to the Medicaid indigent care trust fund



1	for purposes of IC 12-15-20-2(8)(D) IC 12-15-20-2(6)(D) an
2	amount equal to the amount calculated under STEP ONE, minus
3	an amount equal to the amount calculated under STEP THREE.
4	STEP FIVE: The division shall retain an amount equal to the
5	amount remaining in the state hospital care for the indigent fund
6	after the transfer in STEP FOUR for purposes of making
7	payments under section 5 of this chapter.
8	(c) Beginning in state fiscal years after June 30, 2006, funds
9	must be distributed on the following basis and in the following
10	order:
11	(1) Three million dollars (\$3,000,000) must be distributed to
12	physicians and transportation providers.
13	(2) Twenty million six hundred twenty-five thousand dollars
14	(\$20,625,000) must be used for the state match for hospital
15	care for the indigent upper payment limit payments. The
16	payment under this subdivision must equal the 2006 claim
17	payments with the remainder of the money being split on a
18	prorated basis among private hospitals based on Medicaid
19	days.
20	(3) Twenty-eight million dollars (\$28,000,000) to the state
21	Medicaid program.
22	(4) Any remaining money must be used for additional upper
23	payment limit payments to Lake County historical
24	disproportionate share hospitals.
25	(c) (d) The costs of administering the hospital care for the indigent
26	program, including the processing of claims, shall be paid from the
27	funds transferred to the state hospital care for the indigent fund.
28	SECTION 20. IC 12-16-14-3, AS AMENDED BY P.L.246-2005,
29	SECTION 111, IS AMENDED TO READ AS FOLLOWS
30	[EFFECTIVE JULY 1, 2007]: Sec. 3. (a) For purposes of this section,
31	"payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).
32	(b) For taxes first due and payable in 2003, each county shall
33	impose a hospital care for the indigent property tax levy equal to the
34	product of:
35	(1) the county's hospital care for the indigent property tax levy for
36	taxes first due and payable in 2002; multiplied by
37	(2) the county's assessed value growth quotient determined under
38	IC 6-1.1-18.5-2 for taxes first due and payable in 2003.
39	(c) For taxes first due and payable, in 2004, 2005, 2006, 2007, and
40	2008, each county shall impose a hospital care for the indigent property
41	tax levy equal to the product of:
42	(1) the county's hospital care for the indigent property tax levy for



1	taxes first due and payable in the preceding year; multiplied by	
2	(2) the assessed value growth quotient determined in the last	
3	STEP of the following STEPS:	
4	STEP ONE: Determine the three (3) calendar years that most	
5	immediately precede the ensuing calendar year and in which a	
6	statewide general reassessment of real property does not first	
7	become effective.	
8	STEP TWO: Compute separately, for each of the calendar years	
9	determined in STEP ONE, the quotient (rounded to the nearest	
10	ten-thousandth) of the county's total assessed value of all taxable	
11	property in the particular calendar year, divided by the county's	
12	total assessed value of all taxable property in the calendar year	
13	immediately preceding the particular calendar year.	
14	STEP THREE: Divide the sum of the three (3) quotients	
15	computed in STEP TWO by three (3).	
16	(d) Except as provided in subsection (e):	4
17	(1) for taxes first due and payable in 2009, each county shall	
18	impose a hospital care for the indigent property tax levy equal to	
19	the average of the annual amount of payable claims attributed to	
20	the county under IC 12-16-7.5-4.5 during the state fiscal years	
21	beginning:	
22	(A) July 1, 2005;	
23	(B) July 1, 2006; and	
24	(C) July 1, 2007; and	_
25	(2) for all subsequent annual levies under this section, the average	
26	annual amount of payable claims attributed to the county under	
27	IC 12-16-7.5-4.5 during the three (3) most recently completed	
28	state fiscal years.	
29	(e) A county may not impose an annual levy under subsection (d) in	
30	an amount greater than the product of:	
31	(1) The greater of:	
32	(A) the county's hospital care for the indigent property tax levy	
33	for taxes first due and payable in 2008; or	
34	(B) the amount of the county's maximum hospital care for the	
35	indigent property tax levy determined under this subsection for	
36	taxes first due and payable in the immediately preceding year;	
37	multiplied by	
38	(2) the assessed value growth quotient determined in the last	
39	STEP of the following STEPS:	
40	STEP ONE: Determine the three (3) calendar years that most	
41	immediately precede the ensuing calendar year and in which a	
42	statewide general reassessment of real property does not first	



1	become effective.	
2	STEP TWO: Compute separately, for each of the calendar years	
3	determined in STEP ONE, the quotient (rounded to the nearest	
4	ten-thousandth) of the county's total assessed value of all taxable	
5	property in the particular calendar year, divided by the county's	
6	total assessed value of all taxable property in the calendar year	
7	immediately preceding the particular calendar year.	
8	STEP THREE: Divide the sum of the three (3) quotients	
9	computed in STEP TWO by three (3).	
10	SECTION 21. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE	4
11	AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE	
12	JULY 1, 2007]:	`
13	Chapter 10.1. High Risk Hoosiers Under the Healthier Indiana	
14	Insurance Program	
15	Sec. 1. As used in this chapter, "association" means the Indiana	
16	comprehensive health insurance association established by	4
17	IC 27-8-10-2.1.	
18	Sec. 2. As used in this chapter, "covered individual" means an	
19	individual entitled to coverage under the program.	
20	Sec. 3. As used in this chapter, "program" refers to the	
21	healthier Indiana insurance program established by IC 12-15-44-4.	
22	Sec. 4. (a) The association shall administer the program for	
23	individuals who are referred to the association by the office of the	
24	secretary of family and social services.	
25	(b) Coverage under the program is separate from the coverage	
26	provided under IC 27-8-10.	
27	(c) The following apply to the administration of the program	
28	under this chapter:	
29	(1) Only individuals referred by the office of the secretary of	1
30	family and social services are eligible for program coverage	
31	administered under this chapter.	
32	(2) Program coverage administered under this chapter must	
33	provide medical management services.	
34	(d) A covered individual shall participate in medical	
35	management services provided under this chapter.	
36	SECTION 22. THE FOLLOWING ARE REPEALED [EFFECTIVE	
37	JULY 1, 2007]: IC 12-15-15-1.1; IC 12-15-15-1.3; IC 12-15-15-1.5;	
38	IC 12-15-15-1.6; IC 12-15-15-9; IC 12-15-15-9.5; IC 12-15-15-9.6;	
39	IC 12-16-2.5-6.5; IC 12-16-10.5-4; IC 34-30-2-45.2.	
40	SECTION 23. [EFFECTIVE UPON PASSAGE] (a) As used in this	
41	SECTION, "office" refers to the office of Medicaid policy and	
42	planning established by IC 12-8-6-1.	



1	(b) The office shall apply to the United States Department of
2	Health and Human Services for approval of a Section 1115
3	demonstration waiver to develop and implement a health insurance
4	program to cover individuals who meet the following
5	requirements:
6	(1) The individual is at least eighteen (18) years of age and less
7	than sixty-five (65) years of age.
8	(2) The individual is a United States citizen and has been a
9	resident of Indiana for at least twelve (12) months.
10	(3) The individual has an annual household income of:
11	(A) not more than two hundred percent (200%) of the
12	federal income poverty level if the individual is a custodial
13	parent; or
14	(B) at least one hundred percent (100%) and not more
15	than two hundred percent (200%) of the federal income
16	poverty level if the individual is not a custodial parent.
17	(4) The individual is not eligible for health insurance coverage
18	through the individual's employer.
19	(5) The individual has been without health insurance coverage
20	for at least six (6) months or is without health insurance
21	coverage because of a change in employment.
22	(c) The office shall include in the waiver application a request
23	to fund the program in part by using:
24	(1) costs not otherwise matchable dollars; and
25	(2) hospital care for the indigent dollars, upper payment limit
26	dollars, or disproportionate share hospital dollars.
27	(d) The office may not implement the waiver until the office:
28	(1) files an affidavit with the governor attesting that the
29	federal waiver applied for under this SECTION is in effect;
30	and
31	(2) has sufficient funding for the program.
32	The office shall file the affidavit under this subsection not later
33	than five (5) days after the office is notified that the waiver is
34	approved.
35	(e) The office may adopt rules under IC 4-22-2 necessary to
36	implement this SECTION.
37	(f) This SECTION expires December 31, 2013.
38	SECTION 24. [EFFECTIVE UPON PASSAGE] (a) As used in this
39	SECTION, "office" refers to the office of Medicaid policy and
40	planning established by IC 12-8-6-1.
41	(b) The office shall apply to the United States Department of

Health and Human Services for approval of an amendment to the



1	state's Medicaid plan that is necessary to do the following:	
2	(1) Include coverage under the state's Medicaid program for	
3	pregnancy related services for a pregnant woman whose	
4	annual household income does not exceed two hundred	
5	percent (200%) of the federal income poverty level.	
6	(2) Amend the state's upper payment limit program.	
7	(3) Make changes to the state's disproportionate share	
8	hospital program.	
9	(c) The office may not implement an approved amendment to	
10	the state plan until the office files an affidavit with the governor	
11	attesting that the state plan amendment applied for under	
12	subsection (b)(1), (b)(2), or (b)(3) of this SECTION is in effect. The	
13	office shall file the affidavit under this subsection not later than	
14	five (5) days after the office is notified that the state plan	
15	amendment is approved.	
16	(d) The office may adopt rules under IC 4-22-2 necessary to	
17	implement this SECTION.	
18	(e) This SECTION expires December 31, 2013.	
19	SECTION 25. [EFFECTIVE UPON PASSAGE] (a) As used in this	
20	SECTION, "commission" refers to the health finance commission	
21	established by IC 2-5-23-3.	
22	(b) As used in this SECTION, "office" refers to the office of	
23	Medicaid policy and planning established by IC 12-8-6-1.	
24	(c) The office shall report to the commission during the 2007	
25	interim, updating the commission on the status of the development	
26	and implementation of the healthier Indiana insurance program	
27	established by IC 12-15-44-4, as added by this act.	
28	(d) This SECTION expires December 31, 2008.	V
29	SECTION 26. An emergency is declared for this act.	

